INSTRUCTIONS FOR

COMPLETION OF CERTIFICATE OF NEED APPLICATION FOR DESIGNATION AS A PERINATAL FACILITY

SECTION I. GENERAL REQUIREMENTS

1. CERTIFICATE OF NEED

A. PRE-SUBMISSION

Prior to the preparation of the application materials, it is strongly recommended that the applicant discuss the proposed designation with the Maternal and Child Health Consortium for the region, and staff of the New Jersey Department of Health and Senior Services. All information provided on the application shall be in accordance with N.J.A.C. 8:33, N.J.A.C. 8:33A and N.J.A.C. 8:43G.

B. SUBMISSION - NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES

Submit thirty-five (35) copies of the application forms and all required documentation to:

New Jersey Department of Health and Senior Services
Certificate of Need and Acute Care Licensure Program, Room 403
PO Box 360
Trenton, NJ 08625-0360

Applications must be submitted in conjunction with all other regional applications for facilities in accordance with the provisions set forth at N.J.A.C. 8:33C-1.1 et seq.

C. SIGNATURE

All applications must be signed by the current Chief Administrative Officer or Board Chairman of the Hospital.

D. FILING FEE

All applications must be accompanied by a certified check, cashier's check, or money order made payable to "Treasurer, State of New Jersey". Failure to submit the appropriate fee at the time of filing may result in rejection of the application.

Application Fee:

$5,000 (Projects $1,000,000 or less)
$5,000 + 0.15% of Total Project Cost (Projects greater than $1,000,000)

E. COMPLETENESS

1. ALL QUESTIONS REQUIRE AN ANSWER AND MUST BE COMPLETELY FILLED OUT.

2. Certificate of Need forms must be filed in sequential order. Do not re-number pages.

3. All exhibits must be identified as noted herein and attached to the back of the Certificate of Need Application form and referenced to the corresponding item in the appropriate section.

4. Identify each response in the narrative section by question number and respond in sequential order. All additional supporting documentation must be attached to the back of the Certificate of Need form after the exhibits, in Section titled "Appendix".

5. Only complete applications will be processed [N.J.A.C. 8:33-4.5(a)]. Failure to submit all required information and documentation and/or to follow the steps outlined herein when the Certificate of Need is filed may result in a determination that the application is incomplete and, as such, may not be accepted for processing.

F. MODIFICATION

No application may be altered or modified by an applicant after the deadline date for application submission. Additional information shall be permitted only in direct response to written questions submitted to the applicant by the New Jersey Department of Health and Senior Services.

2. MATERNAL AND CHILD HEALTH SERVICES

Application for perinatal designation will result in on-site verification of services and documentation. Questions regarding service delivery, site visits, and designation process should be directed to:

New Jersey Department of Health and Senior Services
Perinatal Health Services
PO Box 364
Trenton, NJ 08625-0364
609-292-5616

3. STATE HEALTH PLANNING

A. Applicants should contact the New Jersey Department of Health and Senior Services, Certificate of Need and Acute Care Licensure Program (609-292-8773) to obtain need projections for hospital-based services.

B. The Hospital Policy Manual (N.J.A.C. 8:33A) may be obtained from the New Jersey Department of Health and Senior Services, Certificate of Need and Acute Care Licensure Program (609-292-8773).

4. LICENSING

Licensing manuals for hospital-based services may be obtained from the New Jersey Department of Health and Senior Services, Certificate of Need and Acute Care Licensure Program (609-292-8773).

5. FINANCIAL

Applicants should contact the New Jersey Department of Health and Senior Services, Health Care Financing Systems (609-984-6298) to obtain information with regard to financial requirements.

6. CONSTRUCTION

Applicants should contact the New Jersey Department of Community Affairs, Health Plans Review Program (609-633-8153) to obtain information regarding construction requirements.

New Jersey Department of Health and Senior Services
Certificate of Need and Acute Care Licensure Program
PO Box 360
Trenton, NJ 08625-0360

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY

INSTRUCTIONS:

All applicants must complete SECTION I, which begins on Page 1 and continues through Page 6, and SECTION VIII, which begins on Page 17. Applicants for the following designations must ALSO complete the appropriate Section indicated:

SECTION I

Name of Facility	Date of Application

Location Address

Mailing Address, If Different

Name of Contact Person	Telephone Number

Name of Consortium of Which Facility is a Member	Source of Data ☐ 3-Year Trend ☐ 1-Year

Previously Approved Designation

Designation Requested

- ☐ Community Perinatal Center-Birthing
- ☐ Community Perinatal Center-Basic
- ☐ Community Perinatal Center-Intermediate
- ☐ Community Perinatal Center-Intensive
- ☐ Regional Perinatal Center
- ☐ Specialty Acute Care Children's Hospital

Number of Licensed Beds (Entire Facility)	Type of Hospital ☐ Public ☐ Private

Description of the Service Area (include a copy of a map showing the service area):

Services Provided

- ☐ Medical/Surgical
- ☐ Pediatrics
- ☐ Critical Care (Adult
- ☐ Critical Care (Neonatal)
- ☐ Obstetrics/Gynecology
- ☐ Psychiatric
- ☐ Critical Care (Pediatric)

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

Population Served:

Race Breakdown:

White: _____
Black: _____
Asian: _____
Native American: _____
Other: _____

Ethnicity Breakdown:

Hispanic: _____
Non-Hispanic: _____

Percent of Payer Mix:

Private Insurance: _____
Managed Care Program (e.g., HMO/PPO): _____
Medicaid: _____
Self-Pay: _____
Charity Care: _____

Age by Percent:

Less than 5 Years: _____
5 - 18 Years: _____
19 - 44 Years: _____
45 - 65 Years: _____
65+ Years _____

Sex by Percent:

Male: _____
Female: _____

Describe any other unique population characteristics in your regional area:

OUTPATIENT DATA

Healthstart Participation:

	PEDIATRIC	**PRENATAL**
a. Is Hospital a Healthstart Provider?	☐ Yes ☐ No	☐ Yes ☐ No
b. If Yes, Provider Number:	_____	_____
c. If No, is Application Pending?	☐ Yes ☐ No	☐ Yes ☐ No
d. If Yes, Date of Application	_____	_____

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

AMBULATORY SERVICES

Prenatal and Postpartum Services:

Days of Operation: _____

Hours of Operation: _____

Staffing (Number of FTE's):

RN's: _____

LPN's: _____

Social Service Personnel: _____

Nutritionists: _____

Nurse Practitioners: _____

Certified Nurse Midwives: _____

Family Practice Physicians: _____

Obstetricians: _____

Location: ☐ On-Site ☐ Satellite

Location, If Off Site: _____

Number of Unduplicated Patients Served: _____

% of Referrals: _____

To Home Follow-Up: _____

To WIC: _____

To High-Risk OB: _____

To Family Planning: _____

% Returning for Postpartum Services: _____

Number of Visits: _____

Percent of Payer Mix:

Private Insurance: _____

Managed Care Programs (e.g., HMO/PPO): _____

Medicaid: _____

% Healthstart: _____

Self-Pay: _____

Charity Care: _____

High-Risk Consultation/Services Available (describe where located, name of provider, and hours available for consultation):

_____

_____

_____

_____

_____

_____

_____

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

AMBULATORY SERVICES, CONTINUED

Pediatric Services:

Days of Operation: _____

Hours of Operation: _____

Staffing (Number of FTE's):

RN's: _____

LPN's: _____

Social Service Personnel: _____

Nutritionists: _____

Nurse Practitioners: _____

Pediatricians: _____

Family Practice Physicians: _____

Location: ☐ On-Site ☐ Satellite

Location, If Off Site: _____

Number of Unduplicated Patients Served: _____

% of Referrals: _____

To Home Visit: _____

To WIC: _____

To Early Intervention: _____

Number of Visits: _____

Percent of Payer Mix:

Private Insurance: _____

Managed Care Programs (e.g., HMO/PPO): _____

Medicaid: _____

% Healthstart: _____

Self-Pay: _____

Charity Care: _____

High-Risk Consultation/Services Available (describe where located, name of provider, and hours available for consultation):

_____

CONSULTANT SERVICES

Consultant Services Available:

	On-Site		By Phone		24-Hour	
Registered Dietician/Nutritionist	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Geneticists/Genetic Counselors	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Social Workers	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Public Health Nurses	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Physician Specialists	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Lactation Consultants	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

INPATIENT DATA

Number of Deliveries Per Year:	Number of Pediatric Admissions:

	Number of Licensed/ Approved Beds/ Bassinets	Patient Days	Occupancy Rate	Average Daily Census	Transfer In	Transfer Out	Total Number of Beds/ Bassinets Requested	Number of Increase/ Decrease In Unit Size
Labor								
Delivery								
Recovery								
LDR								
Postpartum								
LDRP								
Newborn								
Intermediate								
Intensive Unit								

Have any construction Certificates of Need been approved for your facility for the above services?

☐ Yes ☐ No If Yes, include copies of blueprints.

a. Is construction underway or to commence shortly?

☐ Yes ☐ No

b. Specify: _____

_____

_____

Are any construction Certificates of Need pending approval for your facility for the above services?

☐ Yes ☐ No

a. Specify: _____

_____

_____

Will the designation requested in this application require any new construction which will require a Certificate of Need?

☐ Yes ☐ No

Does the facility currently meet all construction standards for the designation being requested?

☐ Yes ☐ No

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

RESIDENCY PROGRAMS

Does your facility have residency programs in the following areas:

Obstetrics?:	☐ Yes	☐ No	If Yes, Number of Current Residents: _____
Pediatrics?	☐ Yes	☐ No	If Yes, Number of Current Residents: _____
Family Practice:	☐ Yes	☐ No	If Yes, Number of Current Residents: _____

Description of Physical Plant for the Above-Mentioned Units and Surgical Suite for C-Sections.

Are all staffing requirements met for the type of designation for which you are applying?

☐ Yes ☐ No

a. If No, explain:

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

SECTION II

TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A COMMUNITY PERINATAL CENTER -BIRTHING CENTER

Number of Maternal-Fetal Transports Made:	Number of Neonatal Transports Made:

Staff Requirements (available on a 24-hour basis and able to arrive within 30 minutes):

Obstetrician	☐ Yes	☐ No
Certified Nurse Midwife	☐ Yes	☐ No
Registered Nurse	☐ Yes	☐ No
Pediatrician	☐ Yes	☐ No

Attach copies of the following documentation:

1. Copy of Perinatal Record Utilized by Providers
2. Copy of Criteria for Transfer in Accordance with Board of Medical Examiners Requirements
3. Copy of Letters of Agreement with Community Perinatal Center-Intermediate, Community Perinatal Center-Intensive, or Regional Perinatal Center for Maternal-Fetal and Neonatal Transports
4. Copy of Contracts with All Required Staff, Including Written Policy for Arrival Time

Describe home follow-up services for women and infants:

Describe family planning services:

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

SECTION III
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A COMMUNITY PERINATAL CENTER -BASIC

Number of Maternal-Fetal Transports Made:	Number of Neonatal Transports Made:

Staff Requirements (available on a 24-hour basis and able to arrive within 30 minutes):

Obstetrician	☐ Yes	☐ No
Pediatrician	☐ Yes	☐ No
Anesthesiologist/Nurse Anesthetist	☐ Yes	☐ No
Registered Nurse (clinical responsibility)	☐ Yes	☐ No

Registered Nurse Staff Ratio (24-Hour in Hospital)

One (1) Registered Nurse whenever Infant in Nursery	☐ Yes	☐ No
Nursing Staff Ratio 1:8	☐ Yes	☐ No

Attach copies of the following documentation:

1. Copy of Perinatal Record Utilized by Providers
2. Copy of Criteria for Transfer
3. Copy of Letters of Agreement with Maternal-Fetal and Neonatal Transports
4. Copy of Contracts with All Required Staff, Including Written Policy for Arrival Time

Describe home follow-up services for women and infants:

Describe family planning services:

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

SECTION IV
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A COMMUNITY PERINATAL CENTER -INTERMEDIATE

Number of Maternal-Fetal Transports Made:	Number of Neonatal Transports Made:

Staff Requirements (available on a 24-hour basis and able to arrive within 30 minutes or in hospital):

Obstetrician or Obstetric Resident with Three (3) Years of Training	☐ Yes	☐ No
Pediatrician with Training and Experience in Neonatal Medicine	☐ Yes	☐ No
Anesthesiologist/Nurse Anesthetist	☐ Yes	☐ No
Registered Nurse (clinical responsibility)	☐ Yes	☐ No

Registered Nurse Staff Ratio:

Newborn (Includes Licensed Nurses) 1:8	☐ Yes	☐ No
Intermediate 1:4	☐ Yes	☐ No

Attach copies of the following documentation:

1. Copy of Perinatal Record Utilized by Providers
2. Copy of Criteria for Transfer
3. Copy of Letters of Agreement with Maternal-Fetal and Neonatal Transports
4. Copy of Contracts with All Required Staff, Including Written Policy for Arrival Time

Describe home follow-up services for women and infants:

Describe family planning services:

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

SECTION V
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A COMMUNITY PERINATAL CENTER -INTENSIVE

Number of Maternal-Fetal Transports Made:	Number of Neonatal Transports Made:	Number of Neonatal Transports Accepted:

Staff Requirements

Available on a 24-hour basis and able to arrive within 30 minutes or in hospital):

Obstetrician	☐ Yes	☐ No
Neonatologist	☐ Yes	☐ No
Anesthesiologist with Special Training in Care of Neonates	☐ Yes	☐ No
Registered Nurse (clinical responsibility)	☐ Yes	☐ No

Available on a 24-hour basis and able to arrive within 30 minutes or in hospital):

Neonatologist, Neonatal Fellow or Pediatrician with Training in Neonatal Medicine	☐ Yes	☐ No

Registered Nurse Staff Ratio:

Newborn (Includes Licensed Nurses) 1:8	☐ Yes	☐ No
Intermediate 1:4	☐ Yes	☐ No
Intensive 1:2	☐ Yes	☐ No

Does your facility have a Neonatal Transport Team?

☐ Yes ☐ No

If Yes, describe team members and vehicles:

Attach copies of the following documentation:

1. Copy of Perinatal Record Utilized by Providers
2. Copy of Criteria for Transfer
3. Copy of Letters of Agreement with Maternal-Fetal and Neonatal Transports Made Out of Facility
4. Copy of Contracts with All Required Staff, Including Written Policy for Arrival Time
5. Copy of Letters of Agreement for Neonatal Transports Accepted

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

SECTION V
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A COMMUNITY PERINATAL CENTER -INTENSIVE

Describe home follow-up services for women and infants:

Describe family planning services:

Describe provision or arrangements for high-risk infant screening and tracking program:

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

SECTION VI
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A REGIONAL PERINATAL CENTER

Number of Maternal-Referrals (include co-managed or delivered at the RPC even if delivered by referring Obstetrician):	Number of Neonatal Transports Accepted:
Number of Low Birthweight Infants Managed:	Number of Very Low Birthweight Infants:
Number of Neonatal Transports Accepted:	Percentage of Transports for the Region:

Attach copies of the following documentation:

1. Copy of Perinatal Record Utilized by Providers
2. Copy of Letters of Agreement with Maternal-Fetal and Neonatal Transports Accepted and Back Transports of Infants
3. Copy of Contracts with All Required Staff, Including Written Policy for Arrival Time
4. Copy of Contracts with Subspecialists, Including Written Policy for Arrival Time

Describe outreach and educational activities to professionals within the region (attach additional documentation if needed):

Describe follow-up home care services for high-risk women and infants:

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

SECTION VI, CONTINUED
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A REGIONAL PERINATAL CENTER

Describe family planning services:

Describe high risk infant screening and tracking program:

Staff Requirements

Available on a 24-hour basis and able to arrive within 30 minutes:		
Perinatologist	☐ Yes	☐ No
Neonatologist	☐ Yes	☐ No
Anesthesiologist with Special Training in Care of Neonates	☐ Yes	☐ No
Perinatal Clinical Specialist (with Master's in MCH)	☐ Yes	☐ No
Available on a 24-hour basis, present in hospital:		
Obstetrician	☐ Yes	☐ No
Neonatologist, Neonatal Fellow or Pediatrician with Training in Neonatal Medicine	☐ Yes	☐ No
Registered Nurse Staff Ratio:		
Newborn (Includes Licensed Nurses) 1:8	☐ Yes	☐ No
Intermediate 1:4	☐ Yes	☐ No
Intensive 1:2	☐ Yes	☐ No

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

SECTION VI, CONTINUED
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION AS A REGIONAL PERINATAL CENTER

How long has the board certified perinatologist been on staff?

_____ Years _____ Months

Does your facility have 24-hour consultation capabilities with subspecialists?

☐ Yes ☐ No

Does your facility have antenatal testing capability?

☐ Yes ☐ No

a. If yes, describe all components and follow-up procedures:

Does your facility have a high-risk prenatal clinic under the direction of a board certified perinatologist?

☐ Yes ☐ No

a. If yes, give location:

Does your facility have a maternal-fetal transport team?

☐ Yes ☐ No

a. If yes, describe team members and vehicle used:

Does your facility have a neonatal transport team?

☐ Yes ☐ No

a. If yes, describe team members and vehicle used:

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

SECTION VII
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION OF
NEONATAL SERVICES AS PART OF A
SPECIALTY ACUTE CARE CHILDREN'S HOSPITAL

Number of Low Birthweight Infants Managed:	Number of Very Low Birthweight Infants Managed:	Number of Neonatal Transports Accepted:

Attach copies of the following documentation:

1. Copy of Contracts with All Required Staff, Including Written Policy for Arrival Time
2. Copy of Letters of Agreement with Regional Perinatal Centers and All Acceptable Community Perinatal Centers Within the Region
3. Copy of Contracts with Subspecialists, Including Written Policy for Arrival Time

Staff Requirements

Board Certified Neonatologist (available ona 24-hour basis, present in the hospital)	☐ Yes	☐ No
Perinatal Clinical Nurse Specialist	☐ Yes	☐ No
Registered Nurse (clinical responsibility)	☐ Yes	☐ No

Registered Nurse Staff Ratio:

Intermediate 1:4	☐ Yes	☐ No
Intensive 1:2	☐ Yes	☐ No

Does your facility have a neonatal transport team?

☐ Yes ☐ No

a. If yes, describe team members and vehicle used:

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

SECTION VII, CONTINUED
TO BE COMPLETED BY FACILITIES APPLYING FOR DESIGNATION OF
NEONATAL SERVICES AS PART OF A
SPECIALTY ACUTE CARE CHILDREN'S HOSPITAL

Describe outreach and educational activities to professionals within the region (attach additional documentation if needed):

Describe high-risk infant screening and tracking program:

Describe subspecialty services available for neonates (e.g., ECMO, transplant surgery, etc.):

APPLICATION FOR CERTIFICATE OF NEED FOR DESIGNATION AS A PERINATAL FACILITY
(Continued)

Name of Facility	Date of Application

SECTION VIII

TO BE COMPLETED BY ALL APPLICANTS

CERTIFICATION BY APPLICANT

I certify that by applying for the perinatal designation specified above in this application, all of the information provided in this application is true and correct to the best of my knowledge and ability.

I further certify that I have read and understand all the requirements of this designation as specified in N.J.A.C. 8:33C and N.J.A.C. 8:43G and that this facility meets all of those requirements for service.

Name of Individual Completing Form	Title

Signature	Date